File No. _____

Certificate No._____

Health Dept._____

Note: If mailing, please attach copy of applicant's photo identification.

MAKE CHECKS PAYABLE TO CITY OF ARLINGTON

Address envelope to:
City of Arlington Vital Records
Mail Stop 63-0700
P.O. Box 90231
Arlington Texas 76004-3231

Phone: 817-459-6777
Physical Address: 201 E Abram, Suite 720

APPLICATION FOR A CERTIFIED COPY OF A BIRTH CERTIFICATE

These records are protected by the Texas Health and Safety Code and may only be released to a "**properly qualified applicant**", which is defined as an immediate member of the family, a legal or personal representative, or agent. Proper identification will be required at the time of order.

* NOTE: **ALL INFORMATION MUST BE COMPLETED BEFORE YOUR ORDER CAN BE PROCESSED.**

* FEES: **$23.00 for each copy.** **NUMBER OF COPIES:** _____

FULL NAME: _____
(**person on record**) first middle last

DATE OF BIRTH: _____ PLACE OF BIRTH: _____
city county state

FULL NAME OF FATHER: _____
first middle last

FULL MAIDEN NAME
OF MOTHER: _____
first middle maiden

NAME OF APPLICANT: _____
(**person signing the application**)

I AM RELATED AS:_____

PURPOSE OF REQUEST: _____
(**reason for purchasing the certificate**)

ADDRESS OF APPLICANT: _____

_____
city state zip phone #

WARNING: THE PENALTY FOR KNOWINGLY MAKING A FALSE STATEMENT ON THIS FORM CAN BE 2-10 YEARS IN PRISON AND A FINE OF UP TO $10,000. (HEALTH AND SAFETY CODE, CHAPTER 195, SEC. 195.003)

_____ _____
SIGNATURE OF APPLICANT DATE

FOR OFFICE USE ONLY:
PROPER IDENTIFICATION PROVIDED YES_____ **NO** _____
TYPE _____ **I.D. NUMBER** _____